ITT HARTFORD

GROUP LIFE CLAIM DIVISION

IMPORTANT — READ CAREFULLY

HARTFORD LIFE INSURANCE COMPANY

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

# STATEMENT OF CLAIM FOR LIVING BENEFITS — GROUP LIFE INSURANCE

## PART 1 STATEMENT OF POLICYHOLDER

| 1. Name of Insured (Employee, Member) | 2. Address of Insured (Employee, Member) | 3. Date of Birth |
|---|---|---|
| | | |

| 4. Amount of Insurance | 5. Social Security No. | 6. Class | 7. Occupation | 8. Wage or Salary |
|---|---|---|---|---|
| | | | | |

| 9. Date Employed | 10. If Employment Terminated, Give Date | 11. Date Last Worked |
|---|---|---|
| | | |

12. Reason For Stopping Work

13. Are Premiums on this Claimant's Life Insurance Currently Being Paid? Yes ☐ No ☐
If "No" Indicate Last Month for Which Premiums Paid. ..... Month ..... Year

14. Effective Date of Life Insurance

15. Date First Disabled

16. Amount of Living Benefit requested* $ _____

17. Has a Conversion Life Insurance policy been issued or applied for? ☐ Yes ☐ No

18. Has a Life Waiver of Premium claim been previously submitted to ITT Hartford? ☐ Yes ☐ No

19. Is Claimant presently receiving Group Long Term Disability benefits from ITT Hartford? ☐ Yes ☐ No

20. Has Claimant assigned any portion of this Life Insurance to another party or parties? (If yes, attach copy of Assignment along with fully completed "Release From Assignment" form.) ☐ Yes ☐ No

Policy Number ..... *Policyholder (Employer, Union)* .....

Date ..... *Signature of Policyholder* ..... Name ..... Title

* Note: The amount may not exceed 50% of the Life Insurance Amount shown in 4 above and is subject to a minimum of $3,000.00 and a maximum of $175,000.00.

## PART 2 STATEMENT OF INSURED EMPLOYEE OR MEMBER

| 1. Name of Insured (Employee, Member) | 2. Address of Insured (Employee, Member) | 3. Date of Birth |
|---|---|---|
| | | |

4. Name and Address of Policyholder (Employer, Union)

5. Nature of Illness or Injury Causing Present Disability

6. On What Date Were You First Totally Disabled So That You Were Wholly Unable to Work? ..... 19 .....

7. Are You Now Wholly Unable to Work? Yes ☐ No ☐

8. If You Are Now Totally Disabled When Do You Expect to Return to Work? Even in a Limited Way? ..... 19 .....

9. Names and Addresses of Physicians Who Have Treated You During Present Disability.

Name ..... From ..... 19 .....

Address ..... To ..... 19 .....

Name ..... From ..... 19 .....

Address ..... To ..... 19 .....

10. Have you applied for a Conversion Life policy from ITT Hartford? ☐ Yes ☐ No

11. Remarks:

**Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.**

I certify that the above statements by me are complete, true, and correctly recorded. I hereby authorize any hospital or physician who has attended or examined me to disclose to ITT Hartford or any of its representatives all information acquired by reason of, and records pertaining to, such hospitalization, examination and attendance. My consent is hereby granted to use this original or a photostatic copy as equally valid authorization.

Date ..... Signature of Insured (Employee, Member) .....

Witness .....

## STATEMENT OF ATTENDING PHYSICIAN — GROUP LIFE INSURANCE 'LIVING BENEFITS' REQUEST

Your patient has requested an advanced payment of benefits on his/her group life insurance policy carried through ITT Hartford. To qualify for this benefit, the patient must have a medical condition that, with reasonable medical certainty, will result in the death of the insured in less than (6) (12) months from the date of this statement. Your assistance is requested to help us determine your patient's eligibility.

| 1. Name of Patient | 2. Date of birth | 3. Social Security Number |
|---|---|---|
| | | |

4. What is the disease causing this patient to be terminally ill? Please provide the diagnosis, objective and subjective findings.

| 5. When did symptoms first appear? | 6. Date patient was informed of diagnosis | 7. Frequency of treatment<br>☐ monthly<br>☐ weekly ☐ other _____ |
|---|---|---|

| 8. First treatment date | 9. Last treatment date | 10. Will the patient's condition, with reasonable medical certainty, result in the patient's death within:<br>☐ six months ☐ twelve months |
|---|---|---|

11. Has this illness affected the mental capacity of the patient? ☐ Yes ☐ No
If "Yes," is the patient still capable of managing his own affairs? ☐ Yes ☐ No

12. Has the patient ever had the same or similar condition? ☐ Yes ☐ No
If "Yes," please state when and describe.

| Physician Name | Degree | Specialty |
|---|---|---|
| | | |

| Physician Address | Telephone |
|---|---|
| | |

Date _____ Signature _____